GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
IMMUNE GLOBULINS PA SUMMARY

PREFERRED	***CMV-IGIV***: CytoGam (Cytomegalovirus Immune Globulin) ***IGIV/IVIG***: Bivigam, Carimune, Flebogamma, Gammagard, Gammaked, Gammaplex, Gamunex, Octagam, Privigen (Immune Globulin Intravenous) ***IGSC/SCIG***: Cuvitru, Gammagard, Gammaked, Gamunex, Hizentra, Hyqvia (Immune Globulin Subcutaneous) ***HBIG***: HepaGam B (Hepatitis B Immune Globulin) ***IGIM/IMIG***: GamaSTAN S/D (Immune Globulin Intramuscular)

LENGTH OF AUTHORIZATION: 1 Year

NOTE:

- If medication is being administered in a physician's office, then it must be billed through the DCH physician's injectable program and not the outpatient pharmacy program. Information regarding the physician's injectable program can be located at www.mmis.georgia.gov.

PA CRITERIA:

CMV-IGIV: CytoGam

- ❖ Approvable for members with the following diagnoses:
  - Prevention of cytomegalovirus (CMV) disease in members undergoing transplantation of kidney, lung, liver, pancreas, or heart
  - Prevention of CMV in recipients of a bone marrow allograft
  - Treatment of CMV pneumonitis in combination with ganciclovir in recipients of a bone marrow allograft.

IGIV/IVIG: Bivigam, Carimune, Flebogamma, Gammagard, Gammaked, Gammaplex, Gamunex, Octagam, Privigen

- ❖ Approvable for members with the following diagnoses:
  - Primary immunodeficiency (PI)
  - Pediatric (age <18) HIV (AIDS)
  - Chronic lymphocytic leukemia (CLL)
  - Kawasaki disease (KD)
  - Chronic inflammatory demyelinating polyneuropathy (CIDP)
  - Idiopathic thrombocytopenic purpura (ITP)
  - Multifocal motor neuropathy (MMN)

AND

- ❖ Member must have received at least one dose under medical supervision.

IGSC/SCIG: Cuvitru, Gammagard, Gammaked, Gamunex, Hizentra, Hyqvia

- ❖ Approvable for members with primary immunodeficiency or chronic inflammatory demyelinating polyneuropathy

AND

- ❖ Member must have received at least one dose under medical supervision.

HBIG: HepaGam B

- ❖ Approvable for members requiring prevention of hepatitis B recurrence following liver transplantation.

IGIM/IMIG: GamaSTAN S/D

- ❖ Approvable for members with immunoglobulin deficiency.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA and APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.